Michigan Mental Health Commission
established by Governor Jennifer Granholm's Executive Order 2003–24

MENTAL HEALTH COMMISSION MEETING SUMMARY

July 26, 2004
Holiday Inn South Convention Center
Lansing, Michigan

Commissioners Present

Patrick Babcock and Waltraud Prechter, Co-chairs; William Allen, Fran Amos, Elizabeth Bauer, Beverly Blaney, Thomas Carli, Patricia Caruso, Bill Gill, Joan Jackson Johnson, Guadalupe Lara, Morna Miller (representing Sander Levin), Kate Lynnes, Milton Mack, Samir Mashni, Andy Meisner, Janet Olszewski, Donna Orrin, Brian Peppler, Mark Reinstein, Roberta Sanders, David Sprey, Sara Stech, Rajiv Tandon, Maxine Thome, Marianne Udow, Thomas Watkins.

The meeting was convened at 8:40 am. Patrick Babcock called the meeting to order and reviewed the agenda for the day. Mr. Babcock asked commissioners to consider the values they identified as a group as they discuss and refine proposed options. He also clarified the cross-cutting issue statements, which present issues emerging from more than one work group. The cross-cutting issues will be discussed today and may eventually serve as an organizing framework for the commission's recommendations.

Approval of June 28 Meeting Summary

The summary of the commission's sixth meeting (June 28) was reviewed by Kate Lynnes. It was noted that the Long-term Care Task Force and Medicaid Task Force mentioned on page 2 are one and the same, and that its first meeting was June 29, not June 28. It was also noted that Andy Meisner's office did recipient rights research in Oakland County, not Wayne County, as mentioned on page 5. Finally, the description of advocacy/protection services on page 6 is confusing; Liz Bauer suggested the following language for the response to the question, What are the differences between MPAS and the state recipient rights office?

> MPAS is a private nonprofit organization designated by the Governor to implement the federally mandated rights protection and advocacy system for people with disabilities in Michigan [**all** disabilities] and the Michigan Mental Health Code [people with mental illness and developmental disabilities]. There are 57 protection and advocacy systems in the United States and territories; most are nonprofit organizations. Exceptions: New York (the Commission on Quality Care is the internal rights agency *and* the protection and advocacy organization; New York contracts with Legal Service Corps to provide required direct legal representation); Ohio (state agency with cabinet-level status); Connecticut, Nevada, and North Carolina are the others that are state agencies.
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> In California the state law was changed about ten years ago to give the responsibility for the state's internal office of recipient rights to the private nonprofit organization, Protection and Advocacy, Inc.

In many states the private nonprofit protection and advocacy organizations are also the states' long-term care ombudsman.

Updates

Commissioner Jeff Patton was commended for the information he sent to the other commissioners. Recent legislation regarding the mental health system includes 1) a bill issued in early July by Senator Beverly Hammerstrom, revising the composition of the board of CMH agencies; 2) a bill authorizing a Department of Community Health grant program; and 3) a bill rescinding the Detroit/Wayne County Community Mental Health Authority. At the National Governors Association annual conference in mid-July, Governor Jennifer Granholm was named chair of the Health and Human Services Committee. She cited the "triple whammy" most states have been dealt: Medicaid inflation of 8–9 percent annually, higher caseloads, and the withdrawal of federal support.

Preliminary Vision Statement

The commissioners discussed the preliminary vision statement that was distributed via e-mail. The main points of that discussion are listed here.

- The phrase "publicly supported…care…to all its citizens" elicited some discussion. How extensive is the role of public support, and is it feasible or desirable for the entire mental health system to be supported by the state? Some commissioners advocated changing the language by either removing "publicly" or adding "and privately" to convey the idea that in order to accomplish our goals, both types of support are needed. Others countered by saying that using both public and private dilutes the message and the charge of this commission.
- There was much support for incorporating "recovery" or "recovery-driven" more strongly into the vision statement, and adding "prevention."
- It was suggested that we try to incorporate language about those things we want to accomplish right now, such as mental health parity. Others suggested that parity be included in a mission statement, because a mission is "what you do" and a vision is "what you want to become." There was support for leaving the vision statement more broad.
- There was some discussion about the inclusion of the word "exemplary" and whether it was necessary to attribute an immeasurable quality to the vision. A counterargument was that "exemplary" challenges the commission and the public to strive for a higher standard.
- Some commissioners believed "offers" was too weak and should be replaced with "provides" or "assures."
- It was noted that eliminating stigma should be part of what we're striving for.

Report Outline

Pat Babcock asked commissioners for comments on the report draft outline that was included in their packets. The commissioners agreed that it would need an executive summary, and that we should ultimately distill those portions of the report that address specific legislature actions, to make the legislative agenda clear. There was some

question about how we see private insurance fitting in, especially if that is added to the vision or mission statements. Finally, the overview of mental health should be revised to begin with a description of what mental illnesses really are and how our understanding has changed over time, followed by a description of the prevalence of mental illnesses and emotional disorders in Michigan. The description of the current system should include populations served.

Pat asked for more comments before the August meeting.

Facilitated Dialogue on the Work Group Proposed Options

Each of the work group chairs briefly reviewed the options put forward to address their respective key issues, prior to the facilitated dialogue on each of the work group topics. The initial briefing elicited the following general comments.

- Having heard all the options together, one commissioner acknowledged it will be difficult to put forth recommendations without identifying funding sources, given the state's current budget situation. Another commissioner countered that the group shouldn't focus so much on the number or cost of the proposed options, but rather on what we are aspiring to, as if money wasn't an issue. From there, the group can figure out how to fund the options.
- Regarding mental health parity (listed by several work groups as a proposed option), one nonvoting commissioner remarked that less than half of those who currently do not receive treatment for mental illness will get treatment, because many who need such treatment don't have private insurance and would not be affected by parity.
- Despite there already being 94 proposed options, there was concern that some options from the initial work group discussions were not included here. Pat Babcock acknowledged that the commission needed to discuss those matters at this meeting, and that after this discussion the project management team would work to pare everything down without excluding important issues. He noted that the initial report will be a staff document, and that commissioners shouldn't assume things will be left out.
- Some commissioners were having trouble looking at the options comprehensively. For instance, would the children and adult issues will be "fit into" whatever the structure, funding, and rights will be? Pat Babcock acknowledged that there are similarities between some of the many proposed options, and the process at this and the next meeting should help shed light on those treatment populations needs.
- One commissioner observed that there is much overlap in the proposed options pertaining to the prevention of mental illness. When the commission's work began, we were worried about funding, and about what the system "should" look like. Today, we're talking about preventing the problems, preventing the system from having to deal with things it shouldn't have to deal with. We have changed the way we're looking at the mental health system, and we shouldn't get so bogged down in our individual work groups. He argued that we've been putting money into the wrong end of the system, and that we should "flip the system over" and reduce the seriously mentally ill population over time.

Governance, Structure, Financing, and Accountability

All of the discussion on this group's proposed options pertained to the idea of central control over the delivery and operation of mental health services. One commissioner thought that the local control pendulum may have swung too far and that we need more enforcement from the state. Another commissioner stated that the Constitution places the buck at the state level and that accountability at the local level must be streamlined for the maximum dollars to go to consumers and direct care workers, not administrators. Many of the commissioners expressed strong support for empowering the Department of Community Health to oversee and regulate local delivery of services with much more authority and staff than they currently have. Commissioners agreed that uniformity of service delivery, data collection, consumer involvement, and rights enforcement was crucial to improving outcomes of those with mental illness who receive treatment. This uniformity can only come through central control, and the department—with additional staff—was better qualified to provide this control than any other entity. Commissioners agreed there should be local delivery of these uniform services.

There was no time to evaluate or discuss the group's proposed options on funding or prevention and early intervention.

Criminal Justice and Human Service Interface

All of the discussion on this work group's proposed options focused on diverting the mentally ill from the criminal justice system into the mental health system. There was general consensus that screening and early diagnosis of mental illness or emotional disorders in children would drastically reduce the juvenile justice population and would ultimately minimize the mentally ill adult population in jails and prisons. To this end, the commissioners discussed full enforcement of the School Aid Act, the Special Education law, and the "child find" mandate to keep children in schools where they can be diagnosed and receive treatment for mental illness. There was also strong support for revoking the portion of the "zero tolerance law" that expels children from school forever if they carry a weapon.

The discussion on proposed options for early intervention and diversion was not limited to the juvenile justice system, as there will always be those in the corrections system who suffer from mental illness. Some commissioners supported the passage of legislation about involuntary commitment, such as Kevin's Law, but urged that it be done with caution. There was general consensus on the subject of training "first responders" to recognize and divert the mentally ill who come into the criminal justice system, as long as it was a cooperative effort among the various agencies involved and funding was available so it was not an unfunded mandate. Real partnerships must be formed between such agencies as DCH, FIA, and Corrections in order to combine or simplify funding streams so departments aren't competing for resources, but rather are leveraging the available resources across departments; discussions about such partnerships are ongoing between DCH and DOC.

Services and Supports for Adults

There was much discussion about the value of and need for an oversight group, as outlined in this work group's proposed options, but no consensus was reached.

Commissioners acknowledged that the concept of an outside panel showed up in almost every group's options, but there was much concern about building a bureaucracy rather than delivering services in the most efficient and effective manner using existing oversight bodies. Many thought that the Department of Community Health, in some changed form, was best suited to implement and oversee the proposed options, and this discussion was related to the earlier discussion on governance and structure. There was general agreement that the people providing services needed to be more closely connected with the people making policy and funding decisions.

The commissioners agreed with the proposal to create an information technology system to compile and analyze data statewide, citing the accountability challenges of the current system. In addition, they liked the option of adopting a "recovery vision," as long as the definition of recovery was easily understood and generally acceptable. Commissioners also discussed the need for long-term care options, particularly for seriously ill adult children of elderly parents. Finally, several commissioners stressed the need for integrating physical and mental health care.

Services and Supports for Children and Families

The commissioners generally agreed that mental health services for children are underfunded, and that more should be done to increase the funding allocation for this population without taking away from other populations. One commissioner again suggested that the School Aid Act should be enforced to hold schools accountable for "child find," in that it would increase early identification of mental illness and emotional disorders. There was also agreement about the shortage of professionals trained to treat children with these disorders: something must be done to either increase the number of specialists in the field or broaden the education and training of pediatricians and encourage incentive-based physician networks.

The transition between high school and higher education was discussed as a critical point for diagnosis and treatment of mental illness. Commissioners agreed that the system should be strengthened in this area, perhaps by employing transition-planning mechanisms in existing education law such as the No Child Left Behind Act. Early identification and treatment of mental illness and emotional disorders was identified as the best strategy to reduce or prevent their occurrence, and schools were decidedly the best place for that identification to take place.

Education, Rights, Outreach, & Advocacy

Members of the commission agreed that education about mental illness is necessary to reduce the stigma that precludes the understanding of it as biologically-based. There was little discussion, however, of how to approach that education, other than applying for grant money from SAMHSA. More time was spent discussing the prospect of an office of recipient rights as a Type 1 Agency. Commissioners weren't certain about whether it was feasible for an agency other than the Medicaid-disbursing agency to administer Medicaid appeals. In addition, although there was general agreement that rights compliance was an important issue deserving attention, there was concern about increasing the bureaucracy by forming a new agency. Commissioners agreed that rights protection processes work in

some areas of the state and not in others, and that a standardized approach would best serve clients throughout the state.

Commissioners agreed with the option of supporting parity legislation, under the condition that it be written with more clarity about the biological nature of mental illness.

Facilitated Dialogue on the Proposed Cross-cutting Issues and Options

The proposed options for each of the cross-cutting issues were briefly explained by the commissioners who developed them, but there was little time for discussion by the full commission. Comments were offered about the data used (the "80-20" rule about Medicaid/non-Medicaid spending is misleading, because half of the state's Medicaid budget is spent on those with developmental disabilities), and about using language that doesn't imply a personal responsibility for mental illness ("fail first").

Most of the brief discussion centered around the funding issue, because all work groups cited a lack of resources as a key issue. Commissioners were generally concerned that the options proposed here would simply be "moving money around," and that prioritizing funding options according to ease may prove to be counterproductive in transforming the mental health system. Commissioners agreed that precise tracking of all current and future funding streams will be essential to build a legislative case for additional funding. Finally, commissioners agreed that the issue of private insurance must be incorporated into any recommendations delivered to the Governor.

Pat Babcock advised that the cross-cutting issues were the beginning of a sorting process to distill ideas from the detailed work group reports.

Assessment of Proposed Options

Ballots were distributed to members of the commission, soliciting their "general agreement" or "general disagreement" with each of the 94 proposed options. Commissioners were instructed to consider the general concept of each option and not get distracted by the details: focus more on the "what" than the "how" and determine their agreement status accordingly. Ballots would be tallied and discussed by the project management team, and used to shape the discussion at the August commission meeting. Pat Babcock advised that the goal of that meeting will be to determine what the remainder of the commission's work will be.

In closing, Pat Babcock recommended that commissioners take advantage of the facility visits that were offered by the Department of Community Health. Judge Mack also invited commissioners to visit the Wayne County probate court on Monday, Wednesday, and Friday mornings to witness the involuntary commitment process.

Public Comment

Chris Valentine—Family advocate. Spoke about his support for specialized supportive transitional living program for persons with a mental illness. Prevents relapse and need for re-hospitalization. This is an important need for persons with a serious and persistent mental illness. Also need to continue providing psychosocial rehabilitation programs. A written copy of this testimony was provided to Commission members.

Larry Lewis—Representing Suicide Prevention Coalition. Spoke about the need for a state association to address suicide prevention. High cost of suicide affects all parts of the state. Need to address suicides in Michigan. Mental illness is associated with 90% of all suicides. Suicides are preventable. Provided a copy of MiSPC's draft Suicide Prevention Plan to Commissioners. He stated that the final report would be available in September and that he would appreciate the opportunity to return to make a formal presentation to the Commission.

Sherman Smith—President of the National Alliance for the Mentally Ill (NAMI) of Hillsdale and Jackson Counties. Stressed how "community" is the key word in community mental health. Spoke about Lifeways CMH and the good services they offer. Lifeways has a good relationship with NAMI and is a role model for collaboration with consumers. Services can be improved, but recommends that the Commission support the CMH system and consider the benefits of the existing programs. Mr. Smith provided written testimony to the Commission.

Floyd Smith—Executive Director of Au Sable Valley CMH. Supports the existing recipient rights system operated by the CMHs with consultation by DCH Office of Recipient Rights (ORR). Questions the proposed recommendation to have a separate ORR—this would remove the current checks and balances provided in the current law. Asks that the Commission consider this recommendation carefully and how it would impact the current system.

Hope Cummins—Representing NAMI of Oakland County. Spoke about access to services. Need to have the CMHs use a common name to identify the agency and its services. Consumers and families find confusing names like Lifeways, Pathways, Northpointe, Summit Pointe, etc. that make no mention of what services are provided. Also need to provide incentives to CMHs to provide adequate jail/prison diversion programs in the community.

Stuart Dunnings—Ingham County Prosecuting Attorney and President-elect of the Prosecuting Attorneys Association of Michigan. Spoke about the need to serve people with a mental illness before they become involved in the criminal justice system. Meeting mental health needs in jails and prisons is very costly ("They have enough problems with the *real* criminals"). The criminal justice system often has no choice but to incarcerate persons with a mental illness when they break the law because appropriate alternatives are not available. Also spoke about the need to redefine the definition of persons who require treatment. Current law is too limited and prevents persons who need treatment from being involuntarily admitted to a hospital.

Lori Edelson—Owner of Birmingham Maple Clinic, an outpatient mental health services provider. Spoke about the importance of parity for mental health insurance coverage. Big differences exist in the coverage for physical health vs. mental health benefits including deductibles, limitation of services, prior approval process, etc. People are often forced into the public mental health system because their private insurance coverage is inadequate. She stated that it is impossible to fix the public system without parity for private insurance. She also stated that "truth in coverage" legislation would help the

public understand the mental health treatment limitations in their coverage. She submitted written testimony to the Commission.

Kathleen Gross—Executive Director of the Michigan Psychiatric Society. Spoke about insurance parity for mental health as not being everything, but still a big improvement. Parity will provide a common understanding that mental health care is as important as physical health care and will improve early intervention services. Parity is opposed by only a few special interest groups. Recommends that the Commission speak up about the importance of parity for mental health care. Ms. Gross submitted written testimony to the Commission.

Elmer Cerano—Executive Director of Michigan Protection and Advocacy and a member of the MDCH Advisory Council on Mental Illness. Recommends that the Commission focus on the needs of the consumers. Can't just "tweak" the existing system; must be a major reform (Referencing an anecdote shared earlier by Judge Mack, Mr. Cerano said, "We can't keep pulling the babies out of the river without going upstream to see who is throwing them in."). Wants Michigan's mental health system to return to being a national model. Commission's response needs to be fiscally sound, pragmatic, and consensus-based. MDCH is responsible for implementing a better system; no need for a long-term commission on mental health after this commission completes its work. Asks that the Commission not lower expectations.

Robert Carr—Retired Sheriff of Muskegon County. Representing the Multi-purpose Collaborative Body of Muskegon County. Spoke about the importance of partnerships in serving persons with mental illnesses; agencies collaborate to provide services. Recommends a central access point for the funds that are used to serve people with a mental illness; pool the total dollars at the local level to get more services for the dollar. Also spoke about the criminal justice system and mental health. Noted good networking in Muskegon County between CMH and jail staff. Need to be committed to make changes to address this population.

Dr. Yousuf—Psychiatrist from New Center Community Mental Health Services in Detroit. Spoke about his experience serving persons with a mental illness. Expressed concern regarding their physical health needs not being adequately addressed, especially true for persons who are obese or who have diabetes. Also spoke about the use of a level of care assessment, which limits the services that people need.

Sally Steiner—Representing the Michigan Office of Services to the Aging. Spoke about: 1) early intervention and prevention, as needs to be addressed, with limited services currently available, 2) work force issues, with number of older adults increasing (the boomers are coming); need to address the availability of direct care workers to serve this population, 3) parity, recommending that the Commission look at other states that have already addressed this issue, and 4) federal initiative, recommending that the Commission consider these initiatives. Substance Abuse and Mental Health Services Administration (SAMHSA) has targeted older adults with mental illness. She provided a copy of the SAMHSA report.

Chris Covetz—Consumer. Spoke about: 1) suicide prevention, noting importance of addressing this issue on college campuses, 2) psychotropic medications, 3) public

expectations of the Commission, expressing his own high expectations of what the Commission will recommend, 4) getting the Heinz C. Prechter Fund on tax forms for donations, and 5) Rose Hill residential treatment facility, recommending consideration be given to how to increase funding for and utilization of this service.